

REMITTANCE ADVICE

OVERVIEW

A remittance advice serves as the provider Explanation of Benefits (EOB) from South Dakota Medicaid. The current status of all claims, including adjustments and voids, that have been processed during the past week are shown on the remittance advice. It is the provider's responsibility to reconcile the Remittance Advice with patient records.

Providers can access their remittance advices via the [Medicaid Portal](#) (Portal) for all adjudicated claims. The Portal allows South Dakota Medicaid Providers the ability to retrieve up to 52 weeks of remittance advices, electronically. The ability to view, save and print remittance advices for a particular Billing NPI or Billing/Servicing NPI combination is determined by the user's Portal account profile and available access. If a user does not have the ability to retrieve remittance advice reports for a specific Billing/Servicing NPI combination, they must send a request to their Portal administrator to have that Billing/Servicing NPI combination added into their account access.

Medicaid Remittance Advice Portal Instructions

A full 52-week history of Medicaid Remittance Advice reports are available on the Portal. 90 days of remittance advices can be viewed at one time. Providers can generate either Combined Remittances by BNPI or a Separate Remittances by BNPI/SNPI. The Combined Remittances by BNPI will generate a combined remittance advice for a Billing NPI including all Servicing NPIs associated with that Billing NPI. The Separate Remittances by BNPI/SNPI option allows you to select Remittance Advice reports you wish to view from a list of Servicing NPIs associated with a Billing NPI.

Providers should use the following instructions to access their remittance advices on the Medicaid Portal.:

1. Login to the Portal.
2. Click on "Medicaid Remittance Advice" from the Reports sub-menu.
3. Select either "Combined Remittances by BNPI" or "Separate Remittances by BNPI/SNPI."
4. Select the "From" and "To" dates being searched.
5. Enter a Billing NPI number into the Billing NPI field.
 - a. If you selected Separate Remittances by BNPI/SNPI, the "Servicing NPI" box will appear with all Servicing NPIs associated to the Billing NPI. Select the complete list by clicking "Select All" or clicking individual SNPI boxes to view specific SNPIs.
6. Click "Create Report"

The screen will refresh and display a single remittance advice for that Billing NPI, that was created within your "From" and "To" date span. Click "View" for the remittance advice you would like to view. The remittance advice opens in a new window.

REFERENCE NUMBER

Each claim line is assigned an individual reference number on a professional (CMS 1500) form. Institutional (UB-04) claims are assigned one reference number for the entire claim. The payment information is shown in the Paid by Program column.

Approved Original

A processed and approved claim paid by South Dakota Medicaid

Adjustments

Providers may adjust an approved claim. After a claim has been adjusted, it cannot be adjusted or voided again. An adjusted claim generates two transactions on the remittance advice:

Credit Adjustments

A credit adjustment reflects the payment amount of the original claim. The remittance advice will indicate a payment amount owed to South Dakota Medicaid as a result of the adjustment. This amount will be deducted from the provider's payment.

Debit Adjustments

A debit adjustment reflects the new payment amount for the adjusted claim.

Voided

A void transaction is shown on the remittance advice as a payment deduction. This amount will be recovered from future claims. Once the void appears on the Remittance Advice, a new claim for services may be resubmitted. After a claim has been voided, it cannot be adjusted or voided again.

Denied

The claim was processed and denied by South Dakota Medicaid and no payment was made. The denial reason will appear on the remittance advice.

Pended Claims

A claim that has been received but not yet adjudicated. The reason for pending the claim is listed on the remittance advice. The provider must wait for claim payment or denial before taking action to void, adjust, or resubmit a pended claim. After the claim has been approved or denied, it will appear on the subsequent remittance advice.

Example Remittance Advice

PHYSICIAN REMITTANCE ADVICE 11/06/2019						DEPT. OF SOCIAL SERVICES MEDICAL SERVICES 700 GOVERNORS DR. PIERRE, SOUTH DAKOTA 57501-2291					
PROVIDER NO:	FED TAX ID NO:	SERVICING NPI:	BILLING NPI:	PAGE NO.	1						
THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:											
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROCEDURE CODE MODIFIERS	NUM SRV	PL SRV	BILLED CHARGES	LESS PAID BY OTHER	PATIENT RESPONSIBILITY	PAID BY PROGRAM
2019308-722470-0	0000000000		10-03-19	10-03-19	58100	1		113.18	.00	.00	113.17
PAT ACCT NO: 2100000000											
2019308-722470-1	0000000000		10-03-19	10-03-19	99243 25	1		102.45	.00	.00	102.44
PAT ACCT NO: 2100000000											
2019310-731350-0	0000000000		09-16-19	09-16-19	59510	1		2,214.24	.00	.00	1,660.86
PAT ACCT NO: 2100000000											
2019309-743340-0	0000000000		10-16-19	10-16-19	90686	1		19.04	.00	.00	17.48
PAT ACCT NO: 2100000000											
2019309-743340-1	0000000000		10-16-19	10-16-19	90471	1		16.72	.00	.00	9.78
PAT ACCT NO: 2100000000											
TOTAL APPROVED ORIGINALS:		5						2,465.63			
						PHYSICIAN	CLAIM TOTAL		1,903.73		
THE FOLLOWING CLAIMS ARE DENIED:											
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROC CODE	BILLED CHARGE	DENY REASON				
2019309-743330-0	0000000000		10-23-19	10-23-19	99241	52.21	PRINCIPAL/PRIMARY DIAGNOSIS INVALID/INCORRECT (ORIG)				
PAT ACCT NO: 2100000000											
RECIPIENT RESP AMT:		.00	HIPAA ADJ REASON CODES: M63								
2019304-721510-0	0000000000		09-05-19	09-05-19	99242	77.51	DIAGNOSIS RESTRICTION FOR AGE OF RECIPIENT (ORIG)				
PAT ACCT NO: 2100000000											
RECIPIENT RESP AMT:		.00	HIPAA ADJ REASON CODES: N657								
TOTAL DENIED CLAIMS:		2									
THE FOLLOWING CLAIMS ARE PENDED FOR REVIEW - PROVIDER DOES NOT NEED TO TAKE ACTION UNLESS FURTHER CONTACT IS MADE:											
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROC CODE	BILLED CHARGE	PEND REASON				
2019308-722460-0	0000000000		10-30-19	10-30-19	58555	295.46	PROCEDURE REQUIRES REVIEW (ORIG)				
PAT ACCT NO: 2100000000											
TOTAL PENDED CLAIMS:		1									

CORRECTING DENIED CLAIMS

Providers should review denied claims and, when appropriate, completely resubmit a new claim with corrections and when necessary for proof of timely filing a copy of the remittance advice indicating the previous denial. CMS 1500 resubmission requiring attachments, should be submitted via the [Online Provider Portal](#). UB-04 resubmissions requiring attachments require a paper claim.

If additional information is required for a denial reason on the 835 remittance, please refer to SD Medicaid's remittance which can be found on the [Online Provider Portal](#). For more information on the HIPAA Adj Reason Codes please refer to <http://www.wpc-edi.com/reference/>.

Top 5 denial reasons

Deny Reason	HIPAA (remittance) ADJ Reason Codes	Claim ADJ Reason Code – X12 External Code Source	Correction options/more information
Taxonomy Code Missing or Invalid	N255 - Missing/incomplete/invalid billing provider taxonomy.	16 – Claim/service lacks information or has submission/billing error(s).	Review the taxonomy codes on your claim, correct and resubmit.
Exact Duplicate of Pend/pd clm – do not resub	M86 - Service denied because payment already made for same/similar	B13 - Previously paid. Payment for this claim/service may have	Review previous remits for paid claim.

Deny Reason	HIPAA (remittance) ADJ Reason Codes	Claim ADJ Reason Code – X12 External Code Source	Correction options/more information
	procedure within set time frame	been provided in a previous payment.	
Procedure/NDC not covered by Medicaid	N643 - The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	96 – Non-covered charge(s).	This service is non-covered; please refer to the appropriate fee schedule for covered services.
Primary Care/Health Home NPI Incorrect	N286 - Missing/incomplete/invalid referring provider primary identifier.	16 – Claim/service lacks information or has submission/billing error(s).	Review the referring NPI; verify an appropriate referral is documented in the medical record, correct and resubmit.
Claim Exceeds 6 Month Limit	N369 - Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.	29 - The time limit for filing has expired.	Refer to ARSD 67:16:35:04 for timely filing specifics.

ADD-PAY/RECOVERY

An Add-Pay Transaction may be initiated for:

- A claim that cannot be paid through the MMIS system
- A check was received to zero out a negative balance on the provider file.
- Additional non-claims related funding paid to providers.

An Add/Pay Deduction may be initiated if:

- A provider did not respond to a request for a refund check for an overpayment.
- A claim has rolled off the system and needs to be refunded to South Dakota Medicaid.
- Overpayment of additional non-claims related funding occurred

When an add/pay adjudicates it will show as 'Add-Pay/Recovery Reason: Miscellaneous' on the line above the Remittance Total. There is no identifying information on the Remittance Advice explaining the recipient or services for which transaction or deduction was made, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL AND PAYMENT

The total amount is determined by adding and subtracting all of the amounts listed under the column “Paid by Program.”

MMIS Remit No. ACH Amount of Check

ACH deposits are mandatory. The net check amount is the “Remittance Total” minus the “YTD Negative Balance.”

CLAIM RESOLUTION AND REMITTANCE ADVICE QUESTIONS

If errors are identified on the remittance advice, please notify South Dakota Medicaid at 1.800.452.7691 as soon as possible.

Providers may contact South Dakota Medicaid for inquiries related to claims listed on the remittance advice at 1.800.452.7691.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

FREQUENTLY ASKED QUESTIONS

1. What if a submitted claim isn’t showing on my remittance advice?

Please allow 30-days for the processing of your claims. If communication is not received on your submitted claim within 30 days, please contact South Dakota Medicaid at 1-800-452-7691.

2. What if I do not agree with South Dakota Medicaid’s determination on the claim?

Please refer to the Reconsiderations Reviews, Coverage Requests, and Fair Hearings manual if you believe your claim was submitted correctly and should have been paid. If the claim denied due to an error on the provider’s part, the provider should submit a new claim with corrected information.

3. How long am I required to keep my remittance advices?

Providers must keep their remittance advices for six years.

4. What if I do not have access to my online remittance advices?

Please contact your provider administrator for the [Online Provider Portal](#) and request access. South Dakota Medicaid cannot grant you access.